

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |   |  |  |                            |
|--|---|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>445224</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                              |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/13/2011</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HENRY COUNTY HEALTHCARE CTR</b> |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>239 HOSPITAL CIRCLE</b><br><b>PARIS, TN 38242</b> |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| F 282  | <p><b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Intakes: TN00026118</p> <p>Based on closed medical record review and interview, it was determined the facility failed to ensure the care plan was implemented for 1 of 24 (Resident #24) sampled residents.</p> <p>The findings included:</p> <p>Closed medical record review for Resident #24 revealed the resident was admitted to the facility on 8/21/09, and discharged on 8/25/09. Admission diagnoses included Spinal Stenosis - Lumbar, Hypercholesterolemia, Hypertension, Fracture Lumbar Vertebra - Closed and Aftercare Internal Fixation Device.</p> <p>The admission care plan for Resident #24 included the following problems and interventions:<br/>a. Problem of "Skin Impairment/Skin Risk/Surgical Wound" with a goal of "Skin Impairment/Skin Risk/Surgical Wound" and an intervention of, "Turn and reposition every 2 hours and as needed."<br/>b. Problem of, "Altered Comfort Related to: Goal: Pain will be addressed and interventions will be effective." Interventions for this problem included,</p> |  |  | F 282   |  |  |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 282  | <p>Continued From page 1</p> <p>"Monitor for constipation with interventions as appropriate."</p> <p>c. Problem of, "Constipation, Goal: Will have a bowel movement every 2- [to] 3 days."</p> <p>Interventions for this problem included, "Monitor for bowel movements and record."</p> <p>Closed medical record review revealed there was no documentation the resident was turned and repositioned every 2 hours or as needed, and no documentation for the resident's bowel movements.</p> <p>In an interview in the Director of Nursing's (DON) office, on 1/13/11 at 8:30 AM, the DON confirmed there was no documentation of bowel movements found in Resident #24's chart.</p> |  |  | F 282   |  |  |                            |